

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297107		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2009	
NAME OF PROVIDER OR SUPPLIER PHYSICIANS CHOICE HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 601 WHITNEY RANCH, BLDG #D22 HENDERSON, NV 89014			
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G 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 25418 This Statement of Deficiencies was generated as a result of the Medicare re-certification survey, conducted at your agency in accordance with 42 CFR Part 484 - Home Health Services from September 10, 2009 through September 18, 2009.</p> <p>The census on the first day of the survey was 134. Fifteen clinical records were reviewed, including three closed records. Five home visits were conducted.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>The agency failed to maintain condition level compliance with the following Conditions of Participation:</p> <p>42 CFR 484.20 - Reporting OASIS Information 42 CFR 484.30 - Skilled Nursing Services 42 CFR 484.55 - Comprehensive Assessment of Patients</p> <p>The following regulatory deficiencies were identified:</p>			G 000			
G 121	<p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD</p> <p>The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA.</p>			G 121			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 121	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 25418</p> <p>Based on observation, interview and document review, the agency failed to ensure staff were compliant with accepted professional standards and principles while caring for 2 of 4 patients observed (Patients #2, 3).</p> <p>Findings include:</p> <p>Patient #2</p> <p>Patient #2 was admitted on 9/11/09 with a moderately sized lower abdominal surgical wound.</p> <p>On 9/11/09 in the morning during a home visit, after Patient #2 had signed all the admission documents, the skilled nurse (SN) washed her hands. The SN got the blood pressure cuff and stethoscope out of her nursing bag and proceeded to use the equipment. The SN put the equipment back into her nursing bag without cleaning it and performing hand hygiene.</p> <p>The SN checked Patient #2's pulse and temperature. The SN put the thermometer back into the nursing bag without cleaning the equipment and performing hand hygiene.</p> <p>The SN put gloves on, removed the packing from Patient #2's wound and then, removed the gloves. The SN did not perform hand hygiene prior to reaching into the nursing bag and retrieving a flashlight.</p> <p>The SN put gloves on and used a long cotton</p>	G 121			

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G 121	<p>Continued From page 2</p> <p>tipped applicator to check for additional packing in Patient #2's wound. The SN removed the gloves and proceeded to open the gauze pad packages without having performed hand hygiene.</p> <p>The SN performed hand hygiene and put hand into bag to obtain a measuring device. The SN put on gloves and measured Patient #2's wound size. The SN removed the gloves and placed her hand into the bag without performing hand hygiene.</p> <p>The nurse then opened gauze packages and used an alcohol pad to clean a pair of scissors without gloves on. Next, the SN put on new gloves and loosely packed Patient #2 's wound. The SN removed the gloves and secured the dressing with tape. There was no hand hygiene after the gloves were removed.</p> <p>The SN placed her flashlight back into the bag without cleaning the flashlight and performing hand hygiene.</p> <p>Patient #3</p> <p>Patient #3 was admitted on 6/15/09 with diagnoses including pressure ulcer of the right heel, aftercare for a fractured tibia/fibula and insulin dependent diabetes mellitus.</p> <p>On 9/11/09 in the afternoon during a visit to Patient #3's home, the SN cleansed the right heel pressure ulcer, and removed her gloves. The SN then put on a new pair of gloves without performing hand hygiene and proceeded to wrap the wound.</p> <p>The SN did not perform hand hygiene before</p>	G 121			

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G 121	Continued From page 3 putting her hand inside the bag for the blood pressure cuff. The SN cleaned her scissors, blood pressure cuff and stethoscope without gloves on. The SN placed the equipment inside the her nursing bag without first performing hand hygiene. On 9/18/09 in the afternoon, the DPS confirmed the SN should be washing their hands between glove changes. According to the agency's undated policy, D-330 Hand Washing revealed "Hand washing is indicated "... 3. d. Between tasks on the same client, and; 3. f. After removing gloves ..."	G 121			
G 134	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, document review and interview, the Administrator failed to ensure annual performance evaluations were completed for 1 of 8 employees (Employee #2).	G 134			

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G 134	Continued From page 4 Findings include: Employee #2 Employee #2 was hired in January, 2004 as a registered nurse to perform patient care visits. On 1/21/08, Employee #2 accepted the position of Director of Professional Services (DPS). The personnel file for Employee #2 lacked documented evidence of an annual performance evaluation for the past three years. According to the agency's undated policy, D-260 Performance Evaluations, "A competency-based performance evaluation will be conducted for all employees after one (1) year of employment and at least annually thereafter..." On 9/18/09 in the morning, the Administrator acknowledged annual performance evaluations were not done for all employees.	G 134			
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, document review and interview, the agency failed to ensure staff maintained liaison and coordination of care for 7 of 15 patients (Patients #1, 5, 6, 8, 9, 10, 11).	G 143			

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G 143	<p>Continued From page 5</p> <p>Findings include:</p> <p>Patient #1</p> <p>Patient #1 was admitted on 8/1/08 (and discharged on 1/15/09) with diagnoses including pressure ulcer of the great toe, edema of both lower extremities, dementia, hypertension, urinary incontinence and generalized weakness.</p> <p>The nursing visit records lacked documented evidence skilled nursing (SN) and physical therapy (PT) communicated with one another regarding Patient #1's status, issues and needs.</p> <p>Patient #5</p> <p>Patient #5 was admitted on 10/4/08 with diagnoses including Parkinson ' s disease and dementia.</p> <p>Skilled nursing (SN) was ordered to see Patient #5 twice a day to prepare and administer anti-tremor medication by subcutaneous injection.</p> <p>On 5/27/09, the SN who saw Patient #5 for the morning visit documented discovery of a new wound on the patient's right heel.</p> <p>On 8/12/09, the evening nurse documented Patient #5's "...color is ashen and mentation lethargic..."</p> <p>The nursing visit records lacked documented evidence the SN who saw the patient in the morning and the SN who saw the patient in the evening communicated with each other regarding Patient #5's status, new conditions and needs.</p>	G 143			

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G 143	<p>Continued From page 6</p> <p>Patient #6</p> <p>Patient #6 was admitted on 3/1/07 with diagnoses including insulin dependent diabetes mellitus, macular degeneration, legally blind and hypertension.</p> <p>Patient #6 was seen by skilled nursing twice a day for blood sugar monitoring and insulin preparation and administration per sliding scale orders.</p> <p>Patient #6's clinical record lacked documented evidence of communication between the skilled nurses seeing the patient from 6/18/09 through 8/16/09.</p> <p>Nursing visit records (NVR) dated 9/1/09 at 12:00 PM, 9/2/09 at 12:00 PM and 3:30 PM , 9/3/09 at 11:30 AM and 3:30 PM and 9/4/09 at 4:00 PM revealed Patient #6 was experiencing fine crackles in the right lower lobe.</p> <p>The clinical record lacked documented evidence the other skilled nurse on the case and Patient #3's physician was notified about the fine crackles in the right lower lobe over four days.</p> <p>Patient #8</p> <p>Patient #8 was admitted on 4/29/08 with diagnoses including insulin dependent diabetes mellitus, dementia, congestive heart failure and legal blindness.</p> <p>Patient #8's plan of care included orders for skilled nursing (SN) to see the patient twice a day for blood glucose monitoring and, if needed,</p>	G 143			

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G 143	<p>Continued From page 7</p> <p>insulin preparation and administration.</p> <p>Two SNs saw Patient #8 on a regular basis. The clinical record lacked documentation of communication between the two SNs regarding the patient's status, issues and needs.</p> <p>Patient #9</p> <p>Patient #9 was admitted on 7/11/09 with diagnoses including rheumatoid arthritis, hypertension, peptic ulcer and deep vein thrombosis.</p> <p>Patient #9 was seen by skilled nursing (SN), certified nursing assistant (CNA) and physical therapy (PT).</p> <p>Documentation in the area of skin condition on the evaluation done by PT revealed Patient #9 had "rash on butt." There was no documentation SN was notified by PT of the rash.</p> <p>Documentation in Patient #9's clinical record revealed PT was discontinued on 8/7/09. The clinical record lacked documented evidence indicating PT communicated the update regarding the discharge and the patient's status to the SN.</p> <p>Patient #10</p> <p>Patient #10 was admitted on 6/5/09 with diagnoses including pressure ulcer of the buttock, failure to thrive, dementia, hypertension and urinary incontinence.</p> <p>Patient #10 was seen by a certified nursing assistant (CNA) two times a week for personal care. The patient was seen by skilled nursing</p>	G 143			

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G 143	Continued From page 8 (SN) once a week. On four visit notes, the CNA documented blood pressure readings of 156/104, 179/99, 184/99 and 198/88 for Patient #10. There was no documentation on the CNA or the SN notes indicating the CNA notified SN regarding the abnormally high blood pressure readings. Patient #11 Patient #11 was admitted on 1/19/09 with diagnoses chronic obstructive pulmonary disease. Patient #11 was seen by skilled nursing (SN) and certified nursing assistant (CNA). The clinical record lacked documented evidence the disciplines communicated with one another regarding the patient's status, needs, etc.	G 143			
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, document review and interview, the agency failed to ensure case conferences occurred on a regular basis for 8 of 15 patients (Patients #1, 3, 5, 6, 9, 11, 13, 15). Findings include:	G 144			

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G 144	<p>Continued From page 9</p> <p>Patient #1</p> <p>Patient #1 was admitted on 8/1/08 with diagnoses including pressure ulcer of the great toe, edema of both lower extremities, dementia, hypertension, urinary incontinence and generalized weakness.</p> <p>On 1/15/09, Patient #1 was transferred to an acute care facility and discharged from the agency.</p> <p>The clinical record for Patient #1 contained a case conference form dated 1/26/09 which was filled out and signed by the office manager and reviewed by the Director of Professional Services (DPS). Under the comments section the note read, "Skilled nurse to continue with wound care per MD's order, teaching patient and caregivers s/s (signs and symptoms) of infection. Under goals the note read, "Ongoing." Under Plan the note read, "discharge when skilled care no longer needed."</p> <p>Patient #3</p> <p>Patient #3 was admitted on 6/15/09 with diagnoses including pressure ulcer of the heel, aftercare for a fractured tibia/fibula and insulin dependent diabetes mellitus.</p> <p>Patient #3 was seen by skilled nursing, certified home health assistant and physical therapy.</p> <p>Patient #3's clinical record lacked documented evidence of case conferences being held to have the different disciplines discuss the patient's problems, situation and plans for the patient's care.</p>	G 144			

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G 144	<p>Continued From page 10</p> <p>Patient #5</p> <p>Patient #5 was admitted on 10/4/08 with diagnoses including Parkinson's disease and dementia.</p> <p>The clinical record for Patient #5 lacked documented evidence of case conferences completed at the midway point of certification periods.</p> <p>Patient #6</p> <p>Patient #6 was admitted on 3/1/07 with diagnoses including insulin dependent diabetes mellitus, macular degeneration, legally blind and hypertension.</p> <p>Patient #6's clinical record lacked documented evidence of case conference at the midway point of the certification period of 6/18/09 through 8/16/09.</p> <p>Patient #9</p> <p>Patient #9 was admitted on 7/11/09 with diagnoses including rheumatoid arthritis, hypertension, peptic ulcer and deep vein thrombosis.</p> <p>Patient #9's clinical record lacked evidence of case conference for the period of 7/11/09 through 9/8/09.</p> <p>Patient #11</p> <p>Patient #11 was admitted on 1/19/09 with diagnoses including chronic obstructive pulmonary disease.</p>	G 144			

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G 144	Continued From page 11 Patient #11's clinical record lacked evidence of case conferences from 1/19/09 through 9/18/09. Patient #13 Patient #13 was admitted on 7/22/09 with diagnoses including insulin dependent diabetes mellitus and urinary incontinence. As of 9/18/09, Patient #13's clinical record lacked documented evidence of a case conference. Patient #15 Patient #15 was admitted on 7/3/09 with exacerbation of chronic obstructive pulmonary disease. As of 9/18/09, Patient #15's clinical record lacked documented evidence of a case conference. According to the agency's undated policy, C-888 Case Conferences, "...2. Case Conferences will be conducted at mid-cert for each patient..." On 9/10/09 at 4:20 PM, the DPS explained, "...we talk to each other about the patients all the time - it just doesn't get written down ... the office manager was supposed to call the nurse and then type up what they said - he would bring me a stack of them and I'd sign off - we took that (task) away from him ... we do case conference after they've been on service 30 days."	G 144			
G 145	484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days.	G 145			

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G 145	<p>Continued From page 12</p> <p>This STANDARD is not met as evidenced by: Surveyor: 25418</p> <p>Based on record review, the agency failed to ensure a complete 60 day summary was prepared for 6 of 15 patients (Patients #1, 5, 6, 8, 9, 11).</p> <p>Findings include:</p> <p>Patient #1</p> <p>Patient #1 was admitted on 8/1/08 with diagnoses including pressure ulcer of the great toe, edema of both lower extremities, dementia, hypertension, urinary incontinence and generalized weakness.</p> <p>The 60 day summary prepared for Patient #1 on 9/24/08 indicated, "Left foot wd (wound) care done, pt (patient) tolerated procedure well. Discussed plan of care c (with) (name), NP (Nurse Practitioner), RN (registered nurse) and (Name of) assisted living facility caregiver. Teaching to pt wd care, drsg (dressing) change, edema care and medications as prescribed, pt stated understanding and compliance. F/U (follow up) needed."</p> <p>The 60 day summary lacked information detailing 1) the progress or lack of progress Patient #1's wound made over the previous 60 days; 2) the beginning size and description of the wound bed and surrounding skin; 3) the amount, type and color of any drainage (or that there was none); 4) the specific wound care ordered at the beginning of the 60 days; 5) how the wound responded to the treatment (or if it did not respond positively),</p>	G 145			

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G 145	<p>Continued From page 13</p> <p>what changes were made and how the wound responded to the new treatment; 6) any new problems that arose and what actions were taken; 7) any changes made to the patient's medications during the 60 day certification period; 8) the fact that physical therapy (PT) saw the patient; and 9) how the patient responded to PT.</p> <p>Patient #5</p> <p>Patient #5 was admitted on 10/4/08 with diagnoses including Parkinson ' s disease and dementia.</p> <p>Patient #5's clinical record lacked a 60 day summary including the patient's status at the beginning of the certification period, what treatments and care were provided during the past 60 days, how the patient was tolerating the treatments and care, any new issues that developed (a new wound on the right foot) and action(s) taken, and plans for the next certification period, including discharge plans.</p> <p>Patient #6</p> <p>Patient #6 was admitted on 3/1/07 with diagnoses including insulin dependent diabetes mellitus, macular degeneration, legally blind and hypertension.</p> <p>Patient #6's clinical record lacked a 60 day summary including the patient's status at the beginning of the certification period, ranges of blood glucose results for the previous 60 days, treatments and care provided during the past 60 days, how the patient tolerated the treatments and care, any new issues that developed, the fact that the patient went to the emergency room with</p>	G 145			

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G 145	Continued From page 14 chest pain on 7/7/09 and was hospitalized from 7/31/09 - 8/2/09 (and why) the fact that the family frequently requested to provide care by themselves and plans for discharge. Patient #8 Patient #8 was admitted on 4/29/08 with diagnoses including insulin dependent diabetes mellitus, dementia, congestive heart failure and legal blindness. Patient #8's clinical record lacked a 60 day summary including the patient's status at the beginning of the certification period, ranges of blood glucose results for the previous 60 days, treatments and care provided during the past 60 days, how the patient tolerated the treatments and care, any new issues that developed and plans for discharge. Patient #9 Patient #9 was admitted on 7/11/09 with diagnoses including rheumatoid arthritis, hypertension, peptic ulcer and deep vein thrombosis. Patient #9's clinical record lacked a 60 day summary. Patient #11 Patient #11 was admitted on 1/19/09 with diagnoses chronic obstructive pulmonary disease. As of 9/18/09, the patient was still on service. There were no 60 day summaries in the patient's clinical record.	G 145			
G 158	484.18 ACCEPTANCE OF PATIENTS, POC,	G 158			

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G 158	<p>Continued From page 15 MED SUPER</p> <p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 25418</p> <p>Based on record review, the agency failed to ensure care provided followed the written plan of care as established by the physician for 11 of 15 patients (Patients #1, 3, 4, 6, 7, 8, 10, 11, 13, 14, 15).</p> <p>Findings include:</p> <p>Patient #1</p> <p>Patient #1 was admitted on 8/1/08 with diagnoses including pressure ulcer of the great toe, edema of both lower extremities, dementia, hypertension, urinary incontinence and generalized weakness.</p> <p>Patient #1's plan of care (POC) for the certification period of 8/1/08 through 9/29/08 included wound care orders which read, "Cleanse with NS (normal saline), pat dry apply Iodosorb (Iodosorb) cover with 4X4 then secure with kerlix and tape."</p> <p>Patient #1's clinical record contained a 9/9/08 nursing visit record (NVR) on which the nurse documented, "Left foot cleansed with wd (wound) cleanser, pat dry, covered with thin Tegaserb ..."</p> <p>On Patient #1's 9/12/08 NVR the nurse documented, "...cleansed with wd (wound)</p>	G 158			

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G 158	<p>Continued From page 16</p> <p>cleanser, pat dry, left open to air..." There was no physician's order in the record to change the wound care.</p> <p>A NVR dated 9/16/08 lacked any documentation regarding wound care to the left foot.</p> <p>On 9/17/08, the nurse wrote on a Verification of Physician's Orders/Plan of Care Update, "...Weight monitoring once weekly..."</p> <p>NVRs in Patient #1's clinical record lacked documented evidence weights were done on 9/22/08 or 9/24/08. The order to weigh the patient weekly was not carried over into the certification period of 9/30/08 through 11/28/08, even though the patient was still experiencing edema in both lower extremities and was on diuretic treatment.</p> <p>The 12/2/08 NVR contained documentation the physician was aware of Patient #1's current weight, however, the weight was not documented on the NVR dated 12/2/08.</p> <p>Patient #1's plan of care for the period 9/30/08 through 11/28/08 included orders for skilled nurse (SN) frequencies of two times a week for six weeks and then one time a week for three weeks.</p> <p>According to documentation in the clinical record, SN: saw Patient #1 one time a week for one week, did not see the patient the second week, saw the patient one time a week for three weeks, two times a week for one week, one time a week for one week, did not see the patient during the eighth week, and saw the patient two times a week during the ninth week.</p>	G 158			

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G 158	<p>Continued From page 17</p> <p>There was no documentation in Patient #1's clinical record indicating SN notified the physician regarding the changes in the number of SN visits to be provided. The clinical record did not have a Plan of Care Update to change the SN visit frequency.</p> <p>Patient #3</p> <p>Patient #3 was admitted on 6/15/09 with diagnoses including pressure ulcer of the heel, aftercare for a fractured tibia/fibula and insulin dependent diabetes mellitus.</p> <p>Patient #3's clinical record included a physician's order for the right heel pressure ulcer to be cleansed with "wound wash." The order was dated 7/17/09.</p> <p>A SN documented on 10 different dated skilled nursing notes the right heel wound was cleansed with normal saline.</p> <p>The 7/17/09 physician's order included a frequency for SN to visit Patient #3 and provide wound care two times a week.</p> <p>According to documentation in the clinical record, SN saw Patient #3 one time during the week of 7/26/09. There was no physician's order in the clinical record to decrease the visits to one time for that week.</p> <p>According to the plan of care and medication profile (MP), Patient #3 was to take Protonix 40 mg one by mouth every day; Lasix 10 milligrams one by mouth every day; use Nasonex one spray each nostril every day, apply a Lidoderm (no dosage noted) patch for 12 hours every day, as</p>	G 158			

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G 158	<p>Continued From page 18</p> <p>well as Lortab 7.5/500 milligram one by mouth every 4 hours; and Coumadin 3 milligrams by mouth every other day and 5 milligrams by mouth on the alternate days.</p> <p>On 9/11/09 in the afternoon, Patient #3 indicated:</p> <ul style="list-style-type: none"> - she no longer needed the Protonix and her physician was aware she stopped taking it on 3/13/09; - the physician changed the Lasix to 40 milligrams on 9/10/09; - she stopped using the Nasonex on 7/4/09; - the physician discontinued the Lidoderm patch on 6/15/09; - she was no longer taking Lortab and Tylenol 500 milligrams one tablet by mouth at bedtime was all she was taking for pain; - the physician prescribed Lisinopril 5 milligrams one by mouth every day and the patient had been taking it since 8/27/09; - she had been taking a multivitamin one by mouth every day since 3/13/09; and - she was taking Coumadin 5 milligrams by mouth Monday through Saturday and Coumadin 3 milligrams by mouth on Sundays since 9/8/09. <p>The MP lacked documented evidence of updates regarding the changes made to Patient #3's medications.</p> <p>Patient #3's Care Plan for the certified nursing</p>	G 158			

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G 158	<p>Continued From page 19</p> <p>assistant (CNA) included 1) mouth care every visit; 2) change bed linens once a week; and 3) observe fall precautions.</p> <p>Twenty-six of 26 CNA notes lacked documented evidence the CNA performed or assisted Patient #3 with mouth care. There was no documentation indicating why the mouth care was not completed during each of the 26 visits. There was no documentation indicating the CNA communicated with the nurse regarding the need to change the care plan.</p> <p>Twenty-six of 26 CNA notes had documentation indicating the CNA changed Patient #3's bed linens twice a week.</p> <p>None of the 26 CNA notes included documentation indicating the CNA observed fall precautions while providing care to Patient #3.</p> <p>Six of 26 CNA notes included documentation indicating the CNA cleaned/filed Patient #3's nails. The Care Plan prepared by the registered nurse did not include instructions to provide nail care. There was no documentation indicating the CNA contacted the SN to revise the care plan.</p> <p>Patient #4</p> <p>Patient #4 was admitted on 8/30/09 with diagnoses including abnormal gait, syncope, non-insulin dependent diabetes mellitus and hypertension.</p> <p>Patient #4's care plan included orders for skilled nursing (SN) to see the patient two times a week for one week, one time a week for eight weeks and four visits as needed for condition change.</p>	G 158			

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G 158	<p>Continued From page 20</p> <p>According to skilled nursing visit notes in Patient #4's clinical record, SN saw the patient one time the first week.</p> <p>Patient #6</p> <p>Patient #6 was admitted on 3/1/07 with diagnoses including insulin dependent diabetes mellitus, macular degeneration, legally blind and hypertension.</p> <p>Patient #6's plan of care for the certification period of 6/18/09 through 8/16/09 included orders to be seen by skilled nursing (SN) twice a day. The clinical record was missing 12 visits for this time frame. The clinical record lacked documentation indicating why each visit was missed. There was no physician's order to decrease the SN visits during this certification period.</p> <p>Patient #6's plan of care for the certification period of 8/17/09 through 10/15/09 included orders to be seen by skilled nursing (SN) twice a day. The clinical record was missing 9 visits for this time frame. The clinical record lacked documentation indicating why each visit was missed. The clinical record lacked a physician's order decreasing the SN visits during this certification period.</p> <p>Patient #7</p> <p>Patient #7 was admitted on 8/26/09 with diagnoses including hypertension, generalized muscle weakness and dementia.</p> <p>Patient #7's plan of care included orders for</p>	G 158			

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G 158	<p>Continued From page 21</p> <p>skilled nursing (SN) to see the patient once a week for nine weeks; occupational therapy (OT) to evaluate; and physical therapy (PT) to see the patient one time a week for one week and then, two times a week for three weeks.</p> <p>According to documents in Patient #7's clinical record:</p> <ul style="list-style-type: none"> - SN saw the patient one time. The clinical record lacked a physician's order to discontinue SN visits; - OT did not see the patient. The clinical record lacked documented evidence explaining why OT had not seen the patient. - PT saw the patient one time a week for one week; two times a week for one week and one time a week for one week. The clinical record lacked a physician's order to decrease the PT visits. <p>Patient #8</p> <p>Patient #8 was admitted on 4/29/08 with diagnoses including insulin dependent diabetes mellitus, dementia, congestive heart failure and legal blindness.</p> <p>Patient #8's plan of care included an update with a physician's order for skilled nursing (SN) to obtain vital signs one time a week.</p> <p>Patient #8's clinical record lacked documentation of vital signs the week of 6/28/09, 7/12/09 and 7/19/09.</p> <p>Patient #10</p>	G 158			

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G 158	<p>Continued From page 22</p> <p>Patient #10 was admitted on 6/5/09 with diagnoses including pressure ulcer of the buttock, failure to thrive, dementia, hypertension and urinary incontinence.</p> <p>Patient #10's plan of care included orders for certified nursing assistant (CNA) two times a week for nine weeks for the certification period of 8/4/09 through 10/2/09.</p> <p>The CNA saw Patient #10 one time during the first week of the certification period of 8/4/09 through 10/2/09.</p> <p>Patient #11</p> <p>Patient #11 was admitted on 1/19/09 with a diagnosis of chronic obstructive pulmonary disease.</p> <p>Patient #11's plan of care included orders for skilled nursing (SN) to see the patient "Q (every week."</p> <p>SN saw Patient #11 one time the first week; then did not see the patient the second and third week.</p> <p>Patient #13</p> <p>Patient #13 was admitted on 7/22/09 with diagnoses including insulin dependent diabetes mellitus and urinary incontinence.</p> <p>Patient #13's plan of care included orders for physical therapy (PT) to see the patient three times a week for one week and two times a week for four weeks.</p>	G 158			

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G 158	<p>Continued From page 23</p> <p>According to documentation in the clinical record, PT saw Patient #13 two times a week for four weeks and one time for one week. There was no physician's order in the clinical record indicating a change in PT nurse frequency.</p> <p>Patient #14</p> <p>Patient #14 was admitted on 8/11/09 with diagnoses including non-insulin dependent diabetes mellitus and a fractured left shoulder.</p> <p>Patient #14's plan of care included orders for skilled nursing (SN) two times a week for one week and then, one time a week for eight weeks.</p> <p>According to documentation in the clinical record, SN saw Patient #14 three times a week for one week, one time a week for one week; did not see the patient for two weeks and then, saw the patient on 9/9/09 to discharge from PT..</p> <p>Patient #14's clinical record lacked a physician's order changing the SN visit frequencies.</p> <p>Patient #15</p> <p>Patient #15 was admitted on 7/3/09 with exacerbation of chronic obstructive pulmonary disease.</p> <p>Patient #15's plan of care included orders for skilled nursing (SN) one time a week for one week, two times a week for two weeks and then, one time a week for six weeks.</p> <p>Documentation in the clinical record revealed SN saw Patient #15 one time a week for two weeks, did not see the patient during the third week, saw</p>	G 158			

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G 158	Continued From page 24 the patient one time a week for five weeks and then, did not see the patient during the last week of the certification period (7/3/09 through 8/31/09). There was no physician's order in the clinical record to change the SN frequency. Patient #15's plan of care included orders for a certified nursing assistant (CNA) two times a week for nine weeks. Documentation in the clinical record revealed the CNA did not see Patient #15 for the first two weeks and saw the patient only one time the third week. There was no physician's order in the clinical record to change the CNA visit frequency. Patient #15's plan of care included orders for physical therapy (PT) one time a week for one week and then two times a week for two weeks. A 7/26/09 physician's order extended PT visits two times a week for two more weeks. Documentation in the clinical record revealed PT saw Patient #15 one time a week for one week, two times a week for two weeks and then one time a week for one week. There was no PT visit note for the fourth week.	G 158			
G 163	484.18(b) PERIODIC REVIEW OF PLAN OF CARE The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the same 60 day episode or more frequently when	G 163			

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G 163	<p>Continued From page 25</p> <p>there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the 60 day episode.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, document review and interview, the agency failed to ensure staff and the physician reviewed the plan of care at least every 60 days for 5 of 15 patients (Patients #3, 9, 11, 13, 15).</p> <p>Findings include:</p> <p>Patient #3</p> <p>Patient #3 was admitted on 6/15/09 with diagnoses including pressure ulcer of the heel, aftercare for a fractured tibia/fibula and insulin dependent diabetes mellitus.</p> <p>Patient #3's certified nursing assistant (CNA) care plan was prepared and dated 6/15/09 by the registered nurse (RN). There was no documentation on the care plan indicating the RN reviewed it during the 60 day time frame of 6/15/09 through 8/13/09.</p> <p>Patient #9</p> <p>Patient #9 was admitted on 7/11/09 with diagnoses including rheumatoid arthritis, hypertension, peptic ulcer and deep vein thrombosis.</p> <p>No OASIS (Outcome and Assessment Information Set) forms were completed during the</p>	G 163			

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G 163	<p>Continued From page 26</p> <p>last five days of Patient #9 ' s initial certification period. Therefore, no plan of care (with orders) was generated.</p> <p>As of 9/18/09, Patient #9's clinical record did not contain a plan of care for the certification period from 9/9/09 through 11/8/09.</p> <p>Patient #11</p> <p>Patient #11 was admitted on 1/19/09 with diagnoses chronic obstructive pulmonary disease.</p> <p>No OASIS (Outcome and Assessment Information Set) forms were completed during the last five days of each of four certification periods. Therefore, no plans of care (with orders) were generated for any of the four certification periods.</p> <p>As of 9/18/09, Patient #11's clinical record did not contain a plan of care for the current certification period of 9/16/09 through 11/14/09.</p> <p>Patient #13</p> <p>Patient #13 was admitted on 7/22/09 with diagnoses including insulin dependent diabetes mellitus and urinary incontinence.</p> <p>No OASIS (Outcome and Assessment Information Set) forms were completed during the last five days of the initial certification period for Patient #13. Therefore, no plan of care (with orders) was generated for the current certification period.</p> <p>Patient #15</p> <p>Patient #15 was admitted on 7/3/09 with</p>	G 163			

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G 163	Continued From page 27 exacerbation of chronic obstructive pulmonary disease. No OASIS (Outcome and Assessment Information Set) forms were completed during the last five days of the initial certification period for Patient #15. Therefore, no plan of care (with orders) was generated for the current certification period of 9/1/09 through 10/30/09. The physician did not review the plans of care for Patients #9, 11, 13 and 15 since the OASIS drives the generation and preparation of the plan of care and no OASIS forms were completed. According to the agency's undated policy, C-480 Plan of Care, "... 8. The total Plan of Care shall be reviewed by the attending physician ... as often as the severity of the client's condition requires, but at least one time every 60 days ..." On 9/17/09 in the afternoon, the director of professional services (DPS) indicated they had been told by the Medicare HMO (health maintenance organization) referral source they only needed to complete the OASIS upon the initial admission and the final discharge visits of the HMO patients.	G 163			
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review and document review,	G 165			

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G 165	<p>Continued From page 28</p> <p>the agency failed to ensure medication and treatments were administered only as ordered by the physician for 9 of 15 patients (Patients #1, 3, 9, 10, 11, 12, 13, 14, 15).</p> <p>Findings include:</p> <p>Patient #1</p> <p>Patient #1 was admitted on 8/1/08 with diagnoses including pressure ulcer of the great toe, edema of both lower extremities, dementia, hypertension, urinary incontinence and generalized weakness.</p> <p>Patient #1's plan of care for the certification period of 8/1/08 through 9/29/08 included orders for wound care as follows: cleanse with NS (normal saline), pat dry, apply iodoserb (Iodosorb) cover with 4X4 then secure with 4X4 and kerlix and tape ... 3X/week. Incisional care: keep incision clean, dry and intact, keep dressing dry and intact ..."</p> <p>On the nursing visit record (NVR) dated 9/12/08 regarding the left foot wound, the SN documented, "... cleansed with wound cleanser, pat dry, left open to air..."</p> <p>The plan of care for the period of 11/29/08 through 01/27/09 orders for the left foot wound read, "...Cleanse with wound cleanser, pat dry, apply thin tegasorb and secure with tape."</p> <p>NVRs dated 12/4/08, 12/12/08, 12/19/08, 12/22/08 and 1/4/09 revealed the nurse soaked Patient #1's left foot in Betadine. The patient's clinical record lacked a physicians order for Betadine soaks to the left foot.</p>	G 165			

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G 165	<p>Continued From page 29</p> <p>On 9/10/09 at 4:30 PM after looking through the entire clinical record for Patient #1, the Director of Nursing acknowledged, "I don't see an order for Betadine in the chart."</p> <p>According to the agency's (undated) policy, C-365 Physicians Orders, "All medications, treatments and services provided to patients must be ordered by a physician... 9. All signed physician orders shall be maintained in the clinical record."</p> <p>Patient #3</p> <p>Patient #3 was admitted on 6/15/09 with diagnoses including pressure ulcer of the heel, aftercare for a fractured tibia/fibula and insulin dependent diabetes mellitus.</p> <p>Patient #3's clinical record included a nursing visit record (NVR) dated 8/13/09, on which the skilled nurse (SN) documented, "The left great toe was cleaned with NS (normal saline), covered with gauze and tape."</p> <p>Patient #3's clinical record included a NVR dated 9/1/09, on which the SN documented, "The wound beds (right heel pressure ulcer and left great toe) were cleaned with normal saline. The wound beds were measured. Triple antibiotic ointment was applied to wound beds ..."</p> <p>Patient #3's clinical record included a NVR dated 9/3/09, on which the SN documented, "The wound beds were cleaned with NS. Antibiotic ointment was applied to right heel ... The left great toe was covered with a Band-Aid. The patient was educated the left great toe is macerated so antibiotic ointment was applied."</p>	G 165			

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G 165	<p>Continued From page 30</p> <p>Patient #3's clinical record included a NVR dated 9/8/09, on which the SN documented, "The wound beds were cleaned with NS. Triple antibiotic cream was applied to the wound beds..."</p> <p>Patient #3's clinical record included a NVR dated 9/11/09, on which the SN documented, "The wound beds were cleaned with Normal Saline. Triple antibiotic ointment was applied to wound beds...Dry gauze and Band-Aid applied to left great toe."</p> <p>Patient #3's clinical record lacked a physician's order for wound care to the left great toe.</p> <p>Patient #9</p> <p>Patient #9 was admitted on 7/11/09 with diagnoses including rheumatoid arthritis, hypertension, peptic ulcer and deep vein thrombosis.</p> <p>Patient #9's clinical record included a nurse visit record (NVR) with documentation indicating a urine specimen was obtained on 7/30/09 for urinalysis and culture and sensitivity. The clinical record lacked a physician's order for these tests.</p> <p>Patient #9's clinical record included a NVR dated 9/2/09 with documentation indicating the SN "...administered Arixtra 5 milligrams SQ (subcutaneously)..." The clinical record lacked a physician's order for Arixtra.</p> <p>Patient #9's clinical record included 12 NVRs dated 9/2/09 through 9/13/09, indicating SN saw the patient 12 days in a row. The clinical record lacked a physician's order for SN to see the</p>	G 165			

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G 165	<p>Continued From page 31 patient daily for 12 days.</p> <p>Patient #10</p> <p>Patient #10 was admitted on 6/5/09 with diagnoses including pressure ulcer of the buttock, failure to thrive, dementia, hypertension and urinary incontinence.</p> <p>Patient #10's plan of care included orders for skilled nursing and certified nursing assistant.</p> <p>On 8/24/09, a medical social worker (MSW) evaluated Patient #10. As of 9/18/09, the clinical record lacked a signed physician's order for MSW to evaluate the patient.</p> <p>Patient #11</p> <p>Patient #11 was admitted on 1/19/09 with diagnoses chronic obstructive pulmonary disease. The plan of care included orders for skilled nursing (SN) "every week" and certified nursing assistant two times a week for two weeks.</p> <p>On 2/3/09, Patient #11 was admitted to the hospital, rendering the initial home health orders null and void.</p> <p>On 2/8/09, SN did a resumption of care visit. No new orders (for SN and CNA frequencies) were generated for Patient #11.</p> <p>No OASIS (Outcome and Assessment Information Set) forms were completed during the last five days of each of four certification periods. Therefore, no plans of care (with orders) were generated.</p>	G 165			

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G 165	<p>Continued From page 32</p> <p>Patient #11 was seen by SN 30 times without physician's orders. The patient was seen by CNA twice a week throughout four certification periods without physician's orders.</p> <p>On 9/17/09 in the afternoon, the director of professional services (DPS) indicated they had been told by the Medicare HMO (health maintenance organization) referral source they only needed to complete the OASIS upon the initial admission and the final discharge visits.</p> <p>Patient #12</p> <p>Patient #12 was admitted on 8/23/98 with a diagnosis of exacerbation of chronic obstructive pulmonary disease.</p> <p>Patient #12's plan of care included orders for skilled nursing (SN) to see the patient one time a week for nine weeks.</p> <p>SN saw the patient two times during the first week on service. The clinical record lacked a physician's order for SN to see Patient #12 for an additional visit.</p> <p>Patient #13</p> <p>Patient #13 was admitted on 7/22/09 with diagnoses insulin dependent diabetes mellitus and urinary incontinence.</p> <p>Patient #13's plan of care lacked orders for skilled nursing (SN) to change the patient's Foley catheter.</p> <p>On nursing visit records (NVR) dated 8/3/09 and 8/20/09, SN documented changing Patient #13's</p>	G 165			

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G 165	<p>Continued From page 33 catheter.</p> <p>Patient #14</p> <p>Patient #14 was admitted on 8/11/09 with diagnoses including non-insulin dependent diabetes mellitus and a fractured left shoulder.</p> <p>Patient #14's plan of care included orders for skilled nursing (SN) two times a week for one week and then, one time a week for eight weeks.</p> <p>According to documentation in the clinical record, SN saw Patient #14 three times a week the first week. Patient #14's clinical record lacked a physician's order to increase SN visit frequencies.</p> <p>Patient #15</p> <p>Patient #15 was admitted on 7/3/09 with a diagnosis of exacerbation of chronic obstructive pulmonary disease.</p> <p>An 8/5/09 nursing visit record revealed skilled nursing (SN) provided care for a skin tear to Patient #15's upper right arm.</p> <p>As of 9/18/09, there was no physician's order for right upper arm wound care in Patient #15's chart.</p> <p>Patient #15's clinical record had a medical social worker (MSW) note dated 8/12/09, revealing the MSW saw the patient on 8/11/09.</p> <p>There was no physician's order for a MSW visit in Patient #15's clinical record.</p> <p>According to the agency's undated policy, C-480 Plan of Care, "...9. Professional staff shall</p>	G 165			

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G 165	Continued From page 34	G 165			
	promptly alert the physician to any changes that suggest a need to alter the Plan of Care..."				
G 168	484.30 SKILLED NURSING SERVICES	G 168			
	This CONDITION is not met as evidenced by: Surveyor: 25418 The agency: failed to furnish skilled nursing services by or under the supervision of a registered nurse (G169); failed to furnish skilled nursing services in accordance with the plan of care (G170); failed to ensure the skilled nurse initiated necessary revisions to the plan of care (G173); failed to ensure the skilled nurse prepared clinical and progress notes and informed the physician and other personnel of changes in the patient's condition and needs (G176); and failed to ensure the skilled nurse participated in in-service programs, and supervised and taught other nursing personnel (G178).				
	The cumulative effect of these systemic problems resulted in the agency's inability to ensure the provision of federally mandated skilled nursing services.				
G 169	484.30 SKILLED NURSING SERVICES	G 169			
	The HHA furnishes skilled nursing services by or under the supervision of a registered nurse.				
	This STANDARD is not met as evidenced by: Surveyor: 25418				
	Based on record review, document review and interview, the agency failed to ensure a registered nurse supervised skilled field staff providing				

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G 169	Continued From page 35 services to patients for 6 of 7 employees (Employees #2, 3, 4, 5, 6, 7). Findings include: On 9/18/09, seven personnel records were reviewed. Personnel records for 6 of 7 employees lacked documented evidence supervisory visits were conducted by a registered nurse(Employees #2, 3, 4, 5, 6, 7). According to the agency's undated policy, C-300 Clinical Supervision, "Skilled nursing and other therapeutic services are provided under the supervision of a Registered Nurse. The Director of Professional Services or a designated qualified Registered Nurse will be available to provide ongoing supervision during the operating hours of the Agency... 1. The Director of Professional Services shall be responsible for the quality of care provided and supervision of all staff providing therapeutic services, including contract staff ... 5. On-site supervision of patients receiving services will be performed by the RN Case Manager to direct, demonstrate, and evaluate the implementation of the Plan of Care and the delivery of services. The frequency and method of supervision will be based on the amount and type of care provided, patient complaints, and changes in patient condition..."	G 169			
G 170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care.	G 170			

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G 170	<p>Continued From page 36</p> <p>This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to ensure care provided followed the written plan of care as established by the physician for 11 of 15 patients (Patients #1, 3, 4, 6, 7, 8, 10, 11, 13, 14, 15).</p> <p>Findings include:</p> <p>Patient #1</p> <p>Patient #1 was admitted on 8/1/08 with diagnoses including pressure ulcer of the great toe, edema of both lower extremities, dementia, hypertension, urinary incontinence and generalized weakness.</p> <p>Patient #1's plan of care (POC) for the certification period of 8/1/08 through 9/29/08 included wound care orders which read, "Cleanse with NS (normal saline), pat dry apply Iodosorb (Iodosorb) cover with 4X4 then secure with kerlix and tape."</p> <p>Patient #1's clinical record contained a 9/9/08 nursing visit record (NVR) on which the nurse documented, "Left foot cleansed with wd (wound) cleanser, pat dry, covered with thin Tegasorb ..."</p> <p>On Patient #1's 9/12/08 NVR the nurse documented, "...cleansed with wd (wound) cleanser, pat dry, left open to air..." There was no physician's order in the record to change the wound care.</p> <p>A NVR dated 9/16/08 lacked any documentation regarding wound care to the left foot.</p>	G 170			

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G 170	<p>Continued From page 37</p> <p>On 9/17/08, the nurse wrote on a Verification of Physician's Orders/Plan of Care Update, "...Weight monitoring once weekly..."</p> <p>NVRs in Patient #1's clinical record lacked documented evidence weights were done on 9/22/08 or 9/24/08. The order to weigh the patient weekly was not carried over into the certification period of 9/30/08 through 11/28/08, even though the patient was still experiencing edema in both lower extremities and was on diuretic treatment.</p> <p>The 12/2/08 NVR contained documentation the physician was aware of Patient #1's current weight, however, the weight was not documented on the NVR dated 12/2/08.</p> <p>Patient #1's plan of care for the period 9/30/08 through 11/28/08 included orders for skilled nurse (SN) frequencies of two times a week for six weeks and then one time a week for three weeks.</p> <p>According to documentation in the clinical record, SN saw Patient #1 one time a week for one week, did not see the patient the second week, saw the patient one time a week for three weeks, two times a week for one week, one time a week for one week, did not see the patient during the eighth week, and saw the patient two times during the ninth week.</p> <p>There was no documentation in Patient #1's clinical record indicating SN notified the physician regarding the changes in the number of SN visits to be provided. The clinical record did not have a Plan of Care Update to change the SN visit frequency.</p>	G 170			

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G 170	<p>Continued From page 38</p> <p>Patient #3</p> <p>Patient #3 was admitted on 6/15/09 with diagnoses including pressure ulcer of the heel, aftercare for a fractured tibia/fibula and insulin dependent diabetes mellitus.</p> <p>Patient #3's clinical record included a physician's order for the right heel pressure ulcer to be cleansed with "wound wash." The order was dated 7/17/09.</p> <p>A SN documented on 10 different dated skilled nursing notes the right heel wound was cleansed with normal saline.</p> <p>The 7/17/09 physician's order included a frequency for SN to visit Patient #3 and provide wound care two times a week.</p> <p>According to documentation in the clinical record, SN saw Patient #3 one time during the week of 7/26/09. There was no physician's order in the clinical record to decrease the visits to one time for that week.</p> <p>According to the plan of care and medication profile (MP), Patient #3 was to take Protonix 40 mg one by mouth every day; Lasix 10 milligrams one by mouth every day; use Nasonex one spray each nostril every day, apply a Lidoderm (no dosage noted) patch for 12 hours every day, as well as Lortab 7.5/500 milligram one by mouth every 4 hours; and Coumadin 3 milligrams by mouth every other day and 5 milligrams by mouth on the alternate days.</p> <p>On 9/11/09 in the afternoon, Patient #3 indicated:</p>	G 170			

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G 170	<p>Continued From page 39</p> <ul style="list-style-type: none"> - she no longer needed the Protonix and her physician was aware she stopped taking it on 3/13/09; - the physician changed the Lasix to 40 milligrams on 9/10/09; - she stopped using the Nasonex on 7/4/09; - the physician discontinued the Lidoderm patch on 6/15/09; - she was no longer taking Lortab and Tylenol 500 milligrams one tablet by mouth at bedtime was all she was taking for pain; - the physician prescribed Lisinopril 5 milligrams one by mouth every day and the patient had been taking it since 8/27/09; - she had been taking a multivitamin one by mouth every day since 3/13/09; and - she was taking Coumadin 5 milligrams by mouth Monday through Saturday and Coumadin 3 milligrams by mouth on Sundays since 9/8/09. <p>The MP lacked documented evidence of updates regarding the changes made to Patient #3's medications.</p> <p>Patient #3's Care Plan for the certified nursing assistant (CNA) included 1) mouth care every visit; 2) change bed linens once a week; and 3) observe fall precautions.</p> <p>Twenty-six of 26 CNA notes lacked documented evidence the CNA performed or assisted Patient</p>	G 170			

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G 170	<p>Continued From page 40</p> <p>#3 with mouth care. There was no documentation indicating why the mouth care was not completed during each of the 26 visits. There was no documentation indicating the CNA communicated with the nurse regarding the need to change the care plan.</p> <p>Twenty-six of 26 CNA notes had documentation indicating the CNA changed Patient #3's bed linens twice a week.</p> <p>None of the 26 CNA notes included documentation indicating the CNA observed fall precautions while providing care to Patient #3.</p> <p>Six of 26 CNA notes included documentation indicating the CNA cleaned/filed Patient #3's nails. The Care Plan prepared by the registered nurse did not include instructions to provide nail care. There was no documentation indicating the CNA contacted the SN to revise the care plan.</p> <p>Patient #4</p> <p>Patient #4 was admitted on 8/30/09 with diagnoses including abnormal gait, syncope, non-insulin dependent diabetes mellitus and hypertension.</p> <p>Patient #4's care plan included orders for skilled nursing (SN) to see the patient two times a week for one week, one time a week for eight weeks and four visits as needed for condition change.</p> <p>According to skilled nursing visit notes in Patient #4's clinical record, SN saw the patient one time the first week.</p> <p>Patient #6</p>	G 170			

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G 170	<p>Continued From page 41</p> <p>Patient #6 was admitted on 3/1/07 with diagnoses including insulin dependent diabetes mellitus, macular degeneration, legally blind and hypertension.</p> <p>Patient #6's plan of care for the certification period of 6/18/09 through 8/16/09 included orders to be seen by skilled nursing (SN) twice a day. The clinical record was missing 12 visits for this time frame. The clinical record lacked documentation indicating why each visit was missed. There was no physician's order to decrease the SN visits during this certification period.</p> <p>Patient #6's plan of care for the certification period of 8/17/09 through 10/15/09 included orders to be seen by skilled nursing (SN) twice a day. The clinical record was missing 9 visits for this time frame. The clinical record lacked documentation indicating why each visit was missed. The clinical record lacked a physician's order decreasing the SN visits during this certification period.</p> <p>Patient #7</p> <p>Patient #7 was admitted on 8/26/09 with diagnoses including hypertension, generalized muscle weakness and dementia.</p> <p>Patient #7's plan of care included orders for skilled nursing (SN) to see the patient once a week for nine weeks; occupational therapy (OT) to evaluate; and physical therapy (PT) to see the patient one time a week for one week and then, two times a week for three weeks.</p>	G 170			

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G 170	<p>Continued From page 42</p> <p>According to documents in Patient #7's clinical record:</p> <ul style="list-style-type: none"> - SN saw the patient one time. The clinical record lacked a physician's order to discontinue SN visits; - OT did not see the patient. The clinical record lacked documented evidence explaining why OT had not seen the patient. - PT saw the patient one time a week for one week; two times a week for one week and one time a week for one week. The clinical record lacked a physician's order to decrease the PT visits. <p>Patient #8</p> <p>Patient #8 was admitted on 4/29/08 with diagnoses including insulin dependent diabetes mellitus, dementia, congestive heart failure and legal blindness.</p> <p>Patient #8's plan of care included an update with a physician's order for skilled nursing (SN) to obtain vital signs one time a week.</p> <p>Patient #8's clinical record lacked documentation of vital signs the week of 6/28/09, 7/12/09 and 7/19/09.</p> <p>Patient #10</p> <p>Patient #10 was admitted on 6/5/09 with diagnoses including pressure ulcer of the buttock, failure to thrive, dementia, hypertension and urinary incontinence.</p>	G 170			

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G 170	<p>Continued From page 43</p> <p>Patient #10's plan of care included orders for certified nursing assistant (CNA) two times a week for nine weeks for the certification period of 8/4/09 through 10/2/09.</p> <p>The CNA saw Patient #10 one time during the first week of the certification period of 8/4/09 through 10/2/09.</p> <p>Patient #11</p> <p>Patient #11 was admitted on 1/19/09 with a diagnosis of chronic obstructive pulmonary disease.</p> <p>Patient #11's plan of care included orders for skilled nursing (SN) to see the patient "Q (every week."</p> <p>SN saw Patient #11 one time the first week; then did not see the patient the second and third week.</p> <p>Patient #13</p> <p>Patient #13 was admitted on 7/22/09 with diagnoses including insulin dependent diabetes mellitus and urinary incontinence.</p> <p>Patient #13's plan of care included orders for physical therapy (PT) to see the patient three times a week for one week and two times a week for four weeks.</p> <p>According to documentation in the clinical record, PT saw Patient #13 two times a week for four weeks and one time for one week. There was no physician's order in the clinical record to change PT visit frequency.</p>	G 170			

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G 170	<p>Continued From page 44</p> <p>Patient #14</p> <p>Patient #14 was admitted on 8/11/09 with diagnoses including non-insulin dependent diabetes mellitus and a fractured left shoulder.</p> <p>Patient #14's plan of care included orders for skilled nursing (SN) two times a week for one week and then, one time a week for eight weeks.</p> <p>According to documentation in the clinical record, SN saw Patient #14 three times a week for one week, one time a week for one week; did not see the patient for two weeks and then, saw the patient on 9/9/09 to discharge from the agency.</p> <p>Patient #14's clinical record lacked a physician's order to change the SN visit frequencies.</p> <p>Patient #15</p> <p>Patient #15 was admitted on 7/3/09 with exacerbation of chronic obstructive pulmonary disease.</p> <p>Patient #15's plan of care included orders for skilled nursing (SN) one time a week for one week, two times a week for two weeks and then, one time a week for six weeks.</p> <p>Documentation in the clinical record revealed SN saw Patient #15 one time a week for two weeks, did not see the patient during the third week, saw the patient one time a week for five weeks and then, did not see the patient during the last week of the certification period (7/3/09 through 8/31/09). There was no physician's order in the clinical record to change the SN visit frequency.</p>	G 170			

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G 170	Continued From page 45 Patient #15's plan of care included orders for a certified nursing assistant (CNA) two times a week for nine weeks. Documentation in the clinical record revealed the CNA did not see Patient #15 for the first two weeks and saw the patient one time the third week. There was no physician's order in the clinical record to change the CNA visit frequency. Patient #15's plan of care included orders for physical therapy (PT) one time a week for one week and then two times a week for two weeks. A 7/26/09 physician's order extended PT visits two times a week for two more weeks. Documentation in the clinical record revealed PT saw Patient #15 one time a week for one week, two times a week for two weeks and then one time a week for one week. There was no PT visit note for the fourth week. There was no physician's order in the clinical record to change the PT visit frequency.	G 170			
G 173	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to ensure the nurse made the necessary revisions to the plans of care for 11 of 15 patients (Patients #1, 3, 4, 6, 7, 8, 10, 11, 13, 14, 15). Findings include:	G 173			

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G 173	<p>Continued From page 46</p> <p>Patient #1</p> <p>Patient #1 was admitted on 8/1/08 with diagnoses including pressure ulcer of the great toe, edema of both lower extremities, dementia, hypertension, urinary incontinence and generalized weakness.</p> <p>Patient #1's plan of care (POC) for the certification period of 8/1/08 through 9/29/08 included wound care orders which read, "Cleanse with NS (normal saline), pat dry apply Iodosorb (Iodosorb) cover with 4X4 then secure with kerlix and tape."</p> <p>Patient #1's clinical record contained a 9/9/08 nursing visit record (NVR) on which the nurse documented, "Left foot cleansed with wd (wound) cleanser, pat dry, covered with thin Tegaserb ..."</p> <p>On Patient #1's 9/12/08 NVR the nurse documented, "...cleansed with wd (wound) cleanser, pat dry, left open to air..." There was no physician's order in the record to change the wound care.</p> <p>A NVR dated 9/16/08 lacked any documentation regarding wound care to the left foot.</p> <p>On 9/17/08, the nurse wrote on a Verification of Physician's Orders/Plan of Care Update, "...Weight monitoring once weekly..."</p> <p>NVRs in Patient #1's clinical record lacked documented evidence weights were done on 9/22/08 or 9/24/08. The order to weigh the patient weekly was not carried over into the certification period of 9/30/08 through 11/28/08, even though the patient was still experiencing edema in both lower extremities and was on</p>	G 173			

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G 173	<p>Continued From page 47</p> <p>diuretic treatment.</p> <p>The 12/2/08 NVR contained documentation the physician was aware of Patient #1's current weight, however, the weight was not documented on the NVR dated 12/2/08.</p> <p>Patient #1's plan of care for the period 9/30/08 through 11/28/08 included orders for skilled nurse (SN) frequencies of two times a week for six weeks and then one time a week for three weeks.</p> <p>According to documentation in the clinical record, SN: saw Patient #1 one time a week for one week, did not see the patient the second week, saw the patient one time a week for three weeks, two times a week for one week, one time a week for one week, did not see the patient during the eighth week, and saw the patient two times a week during the ninth week.</p> <p>There was no documentation in Patient #1's clinical record indicating SN notified the physician regarding the changes in the number of SN visits to be provided. The clinical record did not have a Plan of Care Update to change the SN visit frequency.</p> <p>Patient #3</p> <p>Patient #3 was admitted on 6/15/09 with diagnoses including pressure ulcer of the heel, aftercare for a fractured tibia/fibula and insulin dependent diabetes mellitus.</p> <p>Patient #3's clinical record included a physician's order for the right heel pressure ulcer to be cleansed with "wound wash." The order was dated 7/17/09.</p>	G 173			

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G 173	<p>Continued From page 48</p> <p>A SN documented on 10 different dated skilled nursing notes the right heel wound was cleansed with normal saline.</p> <p>The 7/17/09 physician's order included a frequency for SN to visit Patient #3 and provide wound care two times a week.</p> <p>According to documentation in the clinical record, SN saw Patient #3 one time during the week of 7/26/09. There was no physician's order in the clinical record to decrease the visits to one time for that week. There was no physician's order to change the solution being used to clean the wound.</p> <p>According to the plan of care and medication profile (MP), Patient #3 was to take Protonix 40 mg one by mouth every day; Lasix 10 milligrams one by mouth every day; use Nasonex one spray each nostril every day, apply a Lidoderm (no dosage noted) patch for 12 hours every day, as well as Lortab 7.5/500 milligram one by mouth every 4 hours; and Coumadin 3 milligrams by mouth every other day and 5 milligrams by mouth on the alternate days.</p> <p>On 9/11/09 in the afternoon, Patient #3 indicated:</p> <ul style="list-style-type: none"> - she no longer needed the Protonix and her physician was aware she stopped taking it on 3/13/09; - the physician changed the Lasix to 40 milligrams on 9/10/09; - she stopped using the Nasonex on 7/4/09; 	G 173			

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G 173	<p>Continued From page 49</p> <ul style="list-style-type: none"> - the physician discontinued the Lidoderm patch on 6/15/09; - she was no longer taking Lortab and Tylenol 500 milligrams one tablet by mouth at bedtime was all she was taking for pain; - the physician prescribed Lisinopril 5 milligrams one by mouth every day and the patient had been taking it since 8/27/09; - she had been taking a multivitamin one by mouth every day since 3/13/09; and - she was taking Coumadin 5 milligrams by mouth Monday through Saturday and Coumadin 3 milligrams by mouth on Sundays since 9/8/09. <p>The MP lacked documented evidence of updates regarding the changes made to Patient #3's medications. There was no physician's order updating the patient's current medications.</p> <p>Patient #3's Care Plan for the certified nursing assistant (CNA) included 1) mouth care every visit; 2) change bed linens once a week; and 3) observe fall precautions.</p> <p>Twenty-six of 26 CNA notes lacked documented evidence the CNA performed or assisted Patient #3 with mouth care. There was no documentation indicating why the mouth care was not completed during each of the 26 visits. There was no documentation indicating the CNA communicated with the nurse regarding the need to change the care plan.</p> <p>Twenty-six of 26 CNA notes had documentation indicating the CNA changed Patient #3's bed</p>	G 173			

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G 173	<p>Continued From page 50</p> <p>linens twice a week.</p> <p>None of the 26 CNA notes included documentation indicating the CNA observed fall precautions while providing care to Patient #3.</p> <p>Six of 26 CNA notes included documentation indicating the CNA cleaned/fled Patient #3's nails. The Care Plan prepared by the registered nurse did not include instructions to provide nail care. There was no documentation indicating the skilled nurse modified the care plan in accordance with the patient's preferences.</p> <p>Patient #4</p> <p>Patient #4 was admitted on 8/30/09 with diagnoses including abnormal gait, syncope, non-insulin dependent diabetes mellitus and hypertension.</p> <p>Patient #4's care plan included orders for skilled nursing (SN) to see the patient two times a week for one week, one time a week for eight weeks and four visits as needed for condition change.</p> <p>According to skilled nursing visit notes in Patient #4's clinical record, SN saw the patient one time the first week. There was no physician's order to change the SN frequencies.</p> <p>Patient #6</p> <p>Patient #6 was admitted on 3/1/07 with diagnoses including insulin dependent diabetes mellitus, macular degeneration, legally blind and hypertension.</p> <p>Patient #6's plan of care for the certification</p>	G 173			

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G 173	<p>Continued From page 51</p> <p>period of 6/18/09 through 8/16/09 included orders to be seen by skilled nursing (SN) twice a day. The clinical record was missing 12 visits for this time frame. The clinical record lacked documentation indicating why each visit was missed. There was no physician's order to decrease the SN visits during this certification period.</p> <p>Patient #6's plan of care for the certification period of 8/17/09 through 10/15/09 included orders to be seen by skilled nursing (SN) twice a day. The clinical record was missing 9 visits for this time frame. The clinical record lacked documentation indicating why each visit was missed. The clinical record lacked a physician's order decreasing the SN visits during this certification period.</p> <p>Patient #7</p> <p>Patient #7 was admitted on 8/26/09 with diagnoses including hypertension, generalized muscle weakness and dementia.</p> <p>Patient #7's plan of care included orders for skilled nursing (SN) to see the patient once a week for nine weeks.</p> <p>According to documents in Patient #7's clinical record, SN saw the patient one time. The clinical record lacked a physician's order to discontinue SN visits.</p> <p>Patient #8</p> <p>Patient #8 was admitted on 4/29/08 with diagnoses including insulin dependent diabetes mellitus, dementia, congestive heart failure and</p>	G 173			

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G 173	<p>Continued From page 52 legal blindness.</p> <p>Patient #8's plan of care included an update with a physician's order for skilled nursing (SN) to obtain vital signs one time a week.</p> <p>Patient #8's clinical record lacked documentation of vital signs the week of 6/28/09, 7/12/09 and 7/19/09. There was no physician's order cancelling the order to obtain vital signs once a week.</p> <p>Patient #10</p> <p>Patient #10 was admitted on 6/5/09 with diagnoses including pressure ulcer of the buttock, failure to thrive, dementia, hypertension and urinary incontinence.</p> <p>Patient #10's plan of care for the certification period of 8/4/09 through 10/2/09 included orders for a certified nursing assistant (CNA) two times a week for nine weeks for personal care.</p> <p>The CNA saw Patient #10 one time during the first week of the certification period. The SN failed to make the necessary revisions to the plan of care regarding the CNA visit frequencies.</p> <p>On four visit notes, the CNA documented blood pressure readings of 156/104, 179/99, 184/99 and 198/88 for Patient #10. There was no documentation on the CNA or the SN notes indicating the CNA notified SN regarding the abnormally high blood pressure readings. The SN failed to notify the physician of the readings.</p> <p>Patient #11</p>	G 173			

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G 173	<p>Continued From page 53</p> <p>Patient #11 was admitted on 1/19/09 with a diagnosis of chronic obstructive pulmonary disease.</p> <p>Patient #11's plan of care included orders for skilled nursing (SN) to see the patient "Q (every week."</p> <p>SN saw Patient #11 one time the first week; then did not see the patient the second and third week. The SN failed to make the necessary revisions to the plan of care regarding the SN visit frequencies.</p> <p>Patient #14</p> <p>Patient #14 was admitted on 8/11/09 with diagnoses including non-insulin dependent diabetes mellitus and a fractured left shoulder.</p> <p>Patient #14's plan of care included orders for skilled nursing (SN) two times a week for one week and then, one time a week for eight weeks.</p> <p>According to documentation in the clinical record, SN saw Patient #14 three times a week for one week, one time a week for one week; did not see the patient for two weeks and then, saw the patient on 9/9/09 to discharge from service.</p> <p>The SN failed to make the necessary revisions to the plan of care regarding the change in SN visit frequencies.</p> <p>Patient #15</p> <p>Patient #15 was admitted on 7/3/09 with exacerbation of chronic obstructive pulmonary disease.</p>	G 173			

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G 173	Continued From page 54 Patient #15's plan of care included orders for skilled nursing (SN) one time a week for one week, two times a week for two weeks and then, one time a week for six weeks. Documentation in the clinical record revealed SN saw Patient #15 one time a week for two weeks, did not see the patient during the third week, saw the patient one time a week for five weeks and then, did not see the patient during the last week of the certification period (7/3/09 through 8/31/09). The SN failed to make the necessary revisions to the plan of care regarding the change in Patient #15's SN visit frequencies. Patient #15's plan of care included orders for a certified nursing assistant (CNA) two times a week for nine weeks. Documentation in the clinical record revealed the CNA did not see Patient #15 for the first two weeks and saw the patient one time during the third week. The SN failed to make the necessary revisions to the plan of care regarding the change in Patient #15's CNA visit frequencies.	G 173			
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.	G 176			

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G 176	<p>Continued From page 55</p> <p>This STANDARD is not met as evidenced by: Surveyor: 25418</p> <p>Based on record review, the agency failed to ensure the registered nurse 1) notified the physician of changes in the conditions and needs; and 2) prepared clinical and progress notes for 6 of 15 patients (Patients #1, 5, 6, 9, 10, 15).</p> <p>Findings include:</p> <p>Patient #1</p> <p>Patient #1 was admitted on 8/1/08 with diagnoses including pressure ulcer of the great toe, edema of both lower extremities, dementia, hypertension, urinary incontinence and generalized weakness.</p> <p>Patient #1's clinical record contained a nursing visit record (NVR) dated 10/2/08 which included documentation revealing the patient had developed a second wound on the left foot.</p> <p>There was no documentation indicating the nurse notified Patient #1's physician regarding the new wound.</p> <p>Patient #5</p> <p>Patient #5 was admitted on 10/4/08 with diagnoses including Parkinson's disease and dementia.</p> <p>On 5/27/09, the SN who saw Patient #5 for the morning visit documented discovery of a new wound on the patient's right heel.</p> <p>On 8/12/09, the evening nurse documented Patient #5's "...color is ashen and mentation</p>			G 176			

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G 176	<p>Continued From page 56 lethargic..."</p> <p>The clinical record lacked documented evidence the SN who saw the patient in the morning and the SN who saw the patient in the evening notified the physician regarding Patient #5's status and new findings.</p> <p>Patient #6</p> <p>Patient #6 was admitted on 3/1/07 with diagnoses including insulin dependent diabetes mellitus, macular degeneration, legal blindness and hypertension.</p> <p>According to the intake assessment, Patient #6 was depressed due to the fact that her spouse died the previous week. There was no documentation in the clinical record indicating the nurse notified the physician and attempted to obtain a referral for a social work evaluation and emotional support.</p> <p>On nursing visit records (NVR) dated 8/28/09 at 12:00 PM and 8/29/09 at 12:00 PM, the nurse documented "DM (diabetes mellitus) teaching ... patient verbalized understanding..."</p> <p>The nurse failed to document exactly what Patient #6 was taught during the two visits.</p> <p>On NVRs dated 9/1/09 (two visits), 9/2/09 (two visits), 9/3/09 (two visits), the nurse documented Patient #6 was experiencing fine crackles in the right lower lobe.</p> <p>Patient #6's clinical record lacked documented evidence the nurse called the physician to report on the status of the patient's lung sounds over a</p>	G 176			

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G 176	<p>Continued From page 57 three day period.</p> <p>Patient #9</p> <p>Patient #9 was admitted on 7/11/09 with diagnoses including rheumatoid arthritis, hypertension, peptic ulcer and deep vein thrombosis.</p> <p>Patient #9 was seen by skilled nursing (SN), certified nursing assistant (CNA) and physical therapy (PT).</p> <p>Documentation in the area of skin condition on the evaluation done by PT revealed Patient #9 had "rash on butt." There was no documentation SN was notified by PT of the rash and therefore, no documentation indicating the nurse notified the physician regarding the rash.</p> <p>Patient #10</p> <p>Patient #10 was admitted on 6/5/09 with diagnoses including pressure ulcer of the buttock, failure to thrive, dementia, hypertension and urinary incontinence.</p> <p>Patient #10 was seen by a certified nursing assistant (CNA) two times a week for personal care. The patient was seen by skilled nursing (SN) once a week.</p> <p>On four visit notes, the CNA documented blood pressure readings of 156/104, 179/99, 184/99 and 198/88 for Patient #10. There was no documentation on the CNA or the SN notes indicating the CNA notified SN regarding the abnormally high blood pressure readings. The SN failed to notify the physician of the abnormally</p>	G 176			

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G 176	Continued From page 58 high blood pressure readings. Patient #15 Patient #15 was admitted on 7/3/09 with exacerbation of chronic obstructive pulmonary disease. An 8/5/09 nursing visit record revealed the nurse discovered a skin tear on Patient #15's upper right arm. There was no documentation in the clinical record indicating the nurse notified the physician of the skin tear.	G 176			
G 178	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse participates in in-service programs, and supervises and teaches other nursing personnel. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on interview and document review, the agency failed to ensure the registered nurse participated in in-service programs and supervised and taught other nursing personnel. Findings include: On 9/16/09 in the morning, the Director of Professional Services (DPS) indicated she had arranged a couple of in-services but didn't have the attendees sign in and she had no record of the in-services she had held. According to the agency's undated policy D-320 In-Service Education, "Regularly scheduled in-service programs relevant to their job	G 178			

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G 178	Continued From page 59 classifications, shall be made available for all employees..."	G 178			
G 215	484.36(b)(2)(iii) COMPETENCY EVALUATION & IN-SERVICE TRAINING The home health aide must receive at least 12 hours of in-service training during each 12 month period. The in-service training may be furnished while the aide is furnishing care to the patient. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, the agency failed to ensure at least 12 hours of in-service training per year were received by 1 of 1 certified nursing assistants sampled. Findings include: The certified nursing assistant (CNA) whose file was reviewed, was hired on 11/18/04. The CNA's personnel file lacked documented evidence of 12 hours of inservice training per year for the past three years.	G 215			
G 229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review and document review,	G 229			

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G 229	<p>Continued From page 60</p> <p>the agency failed to ensure certified nursing assistant supervisory visits were made by the registered nurse at least every 14 days for 4 of 15 patients (Patients #3, 9, 11, 15).</p> <p>Findings include:</p> <p>Patient #3</p> <p>Patient #3 was admitted on 6/15/09 with diagnoses including pressure ulcer of the heel, aftercare for a fractured tibia/fibula and insulin dependent diabetes mellitus.</p> <p>Patient #3 had skilled nursing (SN), physical therapy and certified nursing assistant (CNA) services.</p> <p>A CNA supervisory visit for Patient #3 was due on 7/20/09. The SN did the supervisory visit on 7/21/09.</p> <p>Patient #9</p> <p>Patient #9 was admitted on 7/11/09 with diagnoses including rheumatoid arthritis, hypertension, peptic ulcer and deep vein thrombosis.</p> <p>Patient #9 was seen by skilled nursing (SN), physical therapy (PT) and certified nursing assistant (CNA). The clinical record lacked documented evidence of a supervisory visit being done by SN at least every two weeks with the CNA for the certification period of 7/11/09 through 9/8/09.</p> <p>Patient #11</p>	G 229			

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G 229	Continued From page 61 Patient #11 was admitted on 1/19/09 with a diagnosis of chronic obstructive pulmonary disease. Patient #11 was seen by a certified nursing assistant (CNA) two times a week. For the first two certification periods, SN missed the deadline of at least every 14 days for a supervisory visit six times. Patient #15 Patient #15 was admitted on 7/3/09 with exacerbation of chronic obstructive pulmonary disease. Patient #15's plan of care included orders for a certified nursing assistant (CNA) two times a week for nine weeks for personal care assistance. Supervisory visits of the CNA by the skilled nurse (SN) were due on 8/25/09 and 9/8/09. Patient #15's clinical record lacked documented evidence of SN supervisory visits of the CNA on 8/25/09 and 9/8/09. According to the agency's undated policy, C-340 Home Health Aide Supervision, "...3a. ...at least every two (2) weeks to assess relationships and determine whether goals are being met..."	G 229			
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of	G 236			

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G 236	<p>Continued From page 62</p> <p>physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 25418</p> <p>Based on record review and document review, the agency failed to ensure medical histories and pertinent information was obtained from the referral source for 3 of 15 patients (Patient #8, 14, 15).</p> <p>Findings include:</p> <p>Patient #8</p> <p>Patient #8 was admitted on 4/29/08 with diagnoses including insulin dependent diabetes mellitus, dementia, congestive heart failure and legal blindness.</p> <p>Patient #14</p> <p>Patient #14 was admitted on 8/11/09 with diagnoses including non-insulin dependent diabetes mellitus and a fractured left shoulder.</p> <p>Patient #15</p> <p>Patient #15 was admitted on 7/3/09 with exacerbation of chronic obstructive pulmonary disease.</p> <p>Patients #8, 14 and 15's clinical records lacked evidence of a history and physical. There was no</p>	G 236			

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G 236	Continued From page 63 documented evidence indicating a request for the documents was made to the referring physician.	G 236			
G 250	According to the agency's undated policy, C-140 Patient Admission Process, "...10. Past medical information will be requested from the transferring/referring organization..." 484.52(b) CLINICAL RECORD REVIEW At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on documentation review and interview, the agency failed to provide at least quarterly, a review of clinical records by appropriate health professionals, to determine whether established policies were followed in furnishing care to patients. Findings include: The Advisory Board Meeting Minutes dated February 27, 2008, revealed one audit of 10 clinical records was conducted in 2008. There was no documented evidence of additional clinical record audits for 2008. There was no documented evidence of quarterly audits performed on clinical records for the first two quarters of 2009. On 9/15/09 in the afternoon, the Administrator indicated the previous Director of Professional	G 250			

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G 250	Continued From page 64 Services (DPS) was not performing her duties and had to be dismissed ... in January of this year, one of the registered nurses came in from the field to take the position. On 9/15/09 in the afternoon, the DPS revealed she knew exactly what she was supposed to do out in the field but she had never been a DPS before and didn't have any idea what all she was supposed to do in the office.	G 250			
G 320	484.20 REPORTING OASIS INFORMATION HHAs must electronically report all OASIS data collected in accordance with §484.55 This CONDITION is not met as evidenced by: Surveyor: 25418 Based on record review and interview, the agency failed to electronically report all OASIS data (G323).	G 320			
G 323	484.20(c)(1) TRANSMITTAL OF OASIS DATA The HHA must electronically transmit accurate, completed, encoded and locked OASIS data for each patient to the State agency or CMS OASIS contractor at least monthly. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review and interview, the agency failed to ensure completed, accurate, encoded and locked OASIS data was electronically transmitted at least monthly for 4 of 15 patients (Patients 9, 11, 13, 15).	G 323			

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G 323	<p>Continued From page 65</p> <p>Findings include:</p> <p>Patient #9</p> <p>Patient #9 was admitted on 7/11/09 with diagnoses including rheumatoid arthritis, hypertension, peptic ulcer and deep vein thrombosis.</p> <p>As of 9/18/09, Patient #9's clinical record lacked evidence of OASIS comprehensive recertification assessment forms for the certification period of 9/9/09 through 11/7/09.</p> <p>On 9/17/09 in the afternoon, the registered nurse who was case managing Patient #9 indicated the paperwork had not been submitted yet.</p> <p>Patient #11</p> <p>Patient #11 was admitted on 1/19/09 with a diagnosis of chronic obstructive pulmonary disease.</p> <p>As of 9/18/09, Patient #11 had been on service four certification periods. There were no OASIS comprehensive recertification assessments in the clinical record.</p> <p>Patient #13</p> <p>Patient #13 was admitted on 7/22/09 with diagnoses insulin dependent diabetes mellitus and urinary incontinence.</p> <p>As of 9/18/09, Patient #13's clinical record lacked evidence of OASIS comprehensive recertification assessment forms for the certification period of 9/20/09 through 11/18/09.</p>	G 323			

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G 323	Continued From page 66 Patient #15 Patient #15 was admitted on 7/3/09 with exacerbation of chronic obstructive pulmonary disease. As of 9/18/09, Patient #15's clinical record lacked evidence of OASIS comprehensive recertification assessment for the certification period of 9/1/09 through 10/30/09. The referrals for Patients #9, 11, 13 and 15 came from a Medicare HMO (health maintenance organization). On 9/17/09 in the afternoon, the Director of Professional Services (DPS) explained the referral source for the HMO patients recently indicated they only needed to complete admission and discharge OASIS forms for the HMO patients. OASIS forms for all four HMO patients sampled had not been completed and therefore, the data was not transmitted electronically.	G 323			
G 330	484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge	G 330			

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G 330	Continued From page 67 planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary This CONDITION is not met as evidenced by: Surveyor: 25418 Based on clinical record review, policy review and interview, the agency: failed to initiate an admission to the agency within 48 hours of referral (G332); failed to ensure the comprehensive assessments included a complete review of all medications the patient was using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy (G337); and failed to update the comprehensive assessment (G339). The cumulative effect of these systemic practices resulted in the failure of the agency to adequately assess the needs of their patients.	G 330			
G 332	484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. This STANDARD is not met as evidenced by:	G 332			

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G 332	Continued From page 68 Surveyor: 25418 Based on clinical record review and interview, the agency failed to ensure an initial assessment visit was held within 48 hours of receipt of the referral or on a specific date as requested by the patient or physician for 1 of 15 patients (Patient #7). Findings include: Patient #7 Patient #7 was admitted on 8/26/09 with diagnoses including hypertension, generalized muscle weakness and dementia. The referral for Patient #7 was received by the agency on 8/21/09. The date on the initial assessment revealed the initial assessment was done on 8/26/09. There was no documented reason for the delay.	G 332			
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review and document review, the agency failed to ensure comprehensive assessments of all medications were completed and medication profiles were updated for 7 of 15 patients (Patients #1, 3, 6, 7, 8, 9, 11).	G 337			

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G 337	<p>Continued From page 69</p> <p>Findings include:</p> <p>Patient #1</p> <p>Patient #1 was admitted on 8/1/08 with diagnoses including pressure ulcer of the great toe, edema of both lower extremities, dementia, hypertension, urinary incontinence and generalized weakness.</p> <p>The skilled nurse (SN) documented on a nursing visit record (NVR) dated 11/5/08 that Patient #1 was to have Triamcinolone creme 1% applied to her hands twice daily. The clinical record lacked a physician's order for this medication. The clinical record included two medication profiles (MP). Neither of the two MPs in the clinical record were updated with Triamcinolone creme 1%.</p> <p>On a NVR dated 11/7/08, the SN documented Patient #1 was to have Triamcinolone Creme 4% applied once a day. There was no indication in the NVR where on the patient's body this 4% was to be applied. The clinical record lacked a physician's order for this medication. The two MPs in the clinical record were not updated with Triamcinolone creme 4%.</p> <p>On a NVR dated 12/12/08, the SN documented teaching Patient #1 and the caregiver "... regarding Clindamycin use/purpose and adverse reactions, compliance as per MD's ordered." The clinical record lacked a physician's order for this medication. The 11/24/08 MP was not updated with Clindamycin.</p> <p>Patient #3</p>	G 337			

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G 337	<p>Continued From page 70</p> <p>Patient #3 was admitted on 6/15/09 with diagnoses including pressure ulcer of the heel, aftercare for a fractured tibia/fibula and insulin dependent diabetes mellitus.</p> <p>According to the plan of care and medication profile (MP), Patient #3 was to take Protonix 40 mg one by mouth every day; Lasix 10 milligrams one by mouth every day; use Nasonex one spray each nostril every day, apply a Lidoderm (no dosage noted) patch for 12 hours every day, as well as Lortab 7.5/500 milligram one by mouth every 4 hours; and Coumadin 3 milligrams by mouth every other day and 5 milligrams by mouth on the alternate days.</p> <p>On 9/11/09 in the afternoon, Patient #3 indicated the following:</p> <ul style="list-style-type: none"> - she no longer needed the Protonix and her physician was aware she stopped taking it on 3/13/09; - the physician changed the Lasix to 40 milligrams on 9/10/09; - she stopped using the Nasonex on 7/4/09; - the physician discontinued the Lidoderm patch on 6/15/09; - she was no longer taking Lortab and Tylenol 500 milligrams one tablet by mouth at bedtime was all she was taking for pain; - the physician prescribed Lisinopril 5 milligrams one by mouth every day and the patient had been taking it since 8/27/09; 	G 337			

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G 337	<p>Continued From page 71</p> <p>- she had been taking a multivitamin one by mouth every day since 3/13/09; and</p> <p>- she was taking Coumadin 5 milligrams by mouth Monday through Saturday and Coumadin 3 milligrams by mouth on Sundays since 9/8/09.</p> <p>The MP lacked documented evidence of updates regarding the changes made to Patient #3's medications.</p> <p>Patient #6</p> <p>Patient #6 was admitted on 3/1/07 with diagnoses including insulin dependent diabetes mellitus, macular degeneration, legally blind and hypertension.</p> <p>Patient #6's Medication Profile (MP) dated 12/19/08 and "updated" on 2/17/09, 4/16/09 and 6/17/09, indicated the patient was on Coumadin 4 milligrams every day, until it was changed to 3 milligrams sometime in June 2009 (exact date not noted).</p> <p>Patient #6's clinical record included a document titled "Protime/INR Results" dated 8/14/09. According to the information on the form, the patient was taking Coumadin 2 milligrams by mouth daily as of 8/14/09.</p> <p>A Protime/INR results dated 9/9/09 in Patient #6's clinical record indicated an INR result of 1.0. According to the information on the form, the patient was taking Coumadin 2 milligrams by mouth daily.</p> <p>Patient #6's physician ordered the Coumadin to be increased to 4 milligrams by mouth every day.</p>	G 337			

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G 337	<p>Continued From page 72</p> <p>Patient #6's MP dated 8/13/09 (for the certification period of 8/16/09 through 10/14/09) lacked documented evidence of this medication being updated to reflect Coumadin 4 milligrams by mouth daily as of 9/9/09.</p> <p>According to the 7/8/09 nursing visit record in Patient #6's clinical record, Prevacid 30 milligrams one by mouth twice a day was discontinued and the patient was started on Sucralfate one gram four times a day.</p> <p>Patient #6's MP was not updated at that time to reflect the discontinuation of Prevacid and start of Sucralfate.</p> <p>Patient #7</p> <p>Patient #7 was admitted on 8/26/09 with diagnoses including hypertension, generalized muscle weakness and dementia.</p> <p>According to the medication administration record (MAR) kept by the assisted living facility where Patient #7 resided, the patient:</p> <ul style="list-style-type: none"> - was taking Tylenol 500 milligrams two tablets by mouth three times a day (as of 8/27/09) and not four times a day (as listed on the medication profile (MP) in the clinical record); - was on two eye drop solutions beginning on 9/11/09 for several days prior to eye surgery (not listed on MP); - was taking Lipitor 20 milligrams one tablet by mouth every day since 9/2/09 (not listed on MP); and 	G 337			

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G 337	<p>Continued From page 73</p> <p>- was taking Clarinex one tablet by mouth every day as needed for allergies (not listed on MP).</p> <p>Patient #8</p> <p>Patient #8 was admitted on 4/29/08 with diagnoses including insulin dependent diabetes mellitus, dementia, congestive heart failure and legal blindness.</p> <p>Patient #8's medication profile (MP) was not updated to reflect the changes in the patient's medications (taking Novolin insulin, Milk of Magnesia, Hydrocortisone 1% cream, Coreg; not taking Lisinopril, Seroquel) as listed on the medication administration record kept by the facility where the patient resided.</p> <p>Patient #9</p> <p>Patient #9 was admitted on 7/11/09 with diagnoses including rheumatoid arthritis, hypertension, peptic ulcer and history of deep vein thrombosis.</p> <p>On 8/21/09, Patient #9 was admitted to an acute care facility for treatment of a new blood clot in the leg. The patient was discharged home on 8/25/09 with a physician's order for skilled nurse (SN) to administer Lovenox 70 milligrams subcutaneously every 12 hours.</p> <p>According to nursing visit records (NVR) in Patient #9's clinical record, SN administered Arixtra 5 milligrams subcutaneously every day from 9/2/09 through 9/13/09.</p> <p>Patient #9's clinical record lacked a physician's</p>	G 337			

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G 337	Continued From page 74 order for Arixtra. The medication profile was not updated to include Arixtra. Patient #11 Patient #11 was admitted on 1/19/09 with diagnoses chronic obstructive pulmonary disease. Patient #11 was readmitted to the hospital and discharged back home three times during four certification periods. The medication changes ordered upon discharge from the hospital were not noted on the medication profile. According to the agency's undated policy C-700 Medication Profile, "... Purpose ... To provide documentation of the comprehensive assessment of all medications the patient is currently taking, and identify discrepancies between patient profile and the physician and/or agency profile...	G 337			
G 339	484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, document review and	G 339			

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NAME OF PROVIDER OR SUPPLIER PHYSICIANS CHOICE HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 601 WHITNEY RANCH, BLDG #D22 HENDERSON, NV 89014		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 339	<p>Continued From page 75</p> <p>interview, the agency failed to ensure comprehensive assessments were completed during the last five days of every 60 days beginning with the start of care date for 6 of 15 patients (Patients #1, 3, 9, 11, 13, 15).</p> <p>Findings include:</p> <p>Patient #1</p> <p>Patient #1 was admitted on 8/1/08 with diagnoses including pressure ulcer of the great toe, edema of both lower extremities, dementia, hypertension, urinary incontinence and generalized weakness.</p> <p>Patient #1's clinical record contained a recertification comprehensive assessment dated 9/24/08. The certification period at that time was 8/1/08 through 9/29/08. The five day window for the comprehensive assessment to be done was 9/25/08 through 9/29/08. The comprehensive assessment was done one day early.</p> <p>Patient #3</p> <p>Patient #3 was admitted on 6/15/09 with diagnoses including pressure ulcer of the heel, aftercare for a fractured tibia/fibula and insulin dependent diabetes mellitus.</p> <p>As of 9/18/09, Patient #3's clinical record lacked documented evidence of a recertification comprehensive assessment for the certification period of 8/14/09 through 10/12/09.</p> <p>As of 9/18/09, Patient #3's clinical record did not include a plan of care with orders for the current certification period.</p>	G 339			

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G 339	<p>Continued From page 76</p> <p>Patient #9</p> <p>Patient #9 was admitted on 7/11/09 with diagnoses including rheumatoid arthritis, hypertension, peptic ulcer and deep vein thrombosis.</p> <p>On 9/17/09 in the afternoon, the registered nurse who was case managing Patient #9 indicated the paperwork had not been submitted yet.</p> <p>No OASIS (Outcome and Assessment Information Set) forms were completed during the last five days of Patient #9 ' s initial certification period. Therefore, no plan of care (with orders) was generated for the certification period from 9/9/09 through 11/8/09.</p> <p>Patient #11</p> <p>Patient #11 was admitted on 1/19/09 with diagnoses chronic obstructive pulmonary disease.</p> <p>As of 9/18/09, Patient #11 had been on service four certification periods. There were no recertification comprehensive assessments in the clinical record.</p> <p>As of 9/18/09, there was no plan of care with orders in the clinical record for Patient #11 for the current certification period.</p> <p>No OASIS (Outcome and Assessment Information Set) forms were completed during the last five days of the initial certification period for Patient #11. Therefore, no plan of care (with orders) was generated for the current certification period of 9/20/09 through 11/18/09.</p>	G 339			

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G 339	<p>Continued From page 77</p> <p>Patient #13</p> <p>Patient #13 was admitted on 7/22/09 with diagnoses including insulin dependent diabetes mellitus and urinary incontinence.</p> <p>As of 9/18/09, Patient #13's clinical record lacked documented evidence of a recertification comprehensive assessment for the certification period of 9/20/09 through 11/18/09.</p> <p>No OASIS (Outcome and Assessment Information Set) forms were completed during the last five days of the initial certification period for Patient #13. Therefore, no plan of care (with orders) was generated for the current certification period of 9/20/09 through 11/18/09.</p> <p>Patient #15</p> <p>Patient #15 was admitted on 7/3/09 with exacerbation of chronic obstructive pulmonary disease.</p> <p>As of 9/18/09, Patient #15's clinical record lacked documented evidence of a recertification comprehensive assessment for the certification period of 9/1/09 through 10/30/09. There was no plan of care with orders in the clinical record for Patient #15 for the current certification period.</p> <p>The physician did not review the plans of care for Patients # 9, 11, 13 and 15 since the OASIS drives the generation and preparation of the plan of care and no OASIS forms were completed for these patients.</p> <p>According to the agency's undated policy, C-480 Plan of Care, "... 8. The total Plan of Care shall</p>	G 339			

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G 339	Continued From page 78 be reviewed by the attending physician ... as often as the severity of the client's condition requires, but at least one time every 60 days ..." According to the agency's undated policy, C-155 Patient Reassessment/Update of Comprehensive Assessment, " ... Reassessments must be done at least: 1. Every second calendar month beginning with start of care 2. Within forty-eight (48) hours of (or knowledge of) patient return home from hospital admission of more than twenty-four (24) hours for any reason other than diagnostic testing..." On 9/17/09 in the afternoon, the director of professional services (DPS) indicated they were told by the Medicare HMO (health maintenance organization) referral source they only needed to complete the OASIS upon the initial admission and the final discharge visits (for Patients #9, 11, 13 and 15).	G 339			
G 340	484.55(d)(2) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review, document review and interview, the agency failed to ensure a comprehensive assessment including completion of the Outcome and Assessment Information Set (OASIS) was completed within 48 hours of	G 340			

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G 340	<p>Continued From page 79</p> <p>discharge from a hospital admission lasting longer than 24 hours for 2 of 15 patients (Patients #9, 11).</p> <p>Findings include:</p> <p>Patient #9</p> <p>Patient #9 was admitted on 7/11/09 with diagnoses including rheumatoid arthritis, hypertension, peptic ulcer and deep vein thrombosis.</p> <p>According to documentation in Patient #9's clinical record, the patient was transferred to a hospital on 8/21/09 and discharged back home on 8/25/09.</p> <p>As of 9/16/09, the clinical record lacked documented evidence a resumption of care comprehensive assessment was done after Patient #9 returned home on 8/25/09.</p> <p>Patient #11</p> <p>Patient #11 was admitted on 1/19/09 with exacerbation of chronic obstructive pulmonary disease. The plan of care included orders for skilled nursing (SN) and certified nursing assistant (CNA).</p> <p>Patient #11 was admitted to the hospital on 2/3/09 and discharged home on 2/7/09. SN saw the patient on 2/8/09. There was no comprehensive resumption of care assessment dated 2/8/09 in the patient's clinical record.</p> <p>Patient #11 was admitted to the hospital on 5/9/09 and discharged home on 5/13/09. SN saw</p>	G 340			

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G 340	<p>Continued From page 80</p> <p>the patient on 5/14/09. There was no comprehensive resumption of care assessment dated 5/14/09 in the patient's clinical record.</p> <p>Patient #11 was admitted to the hospital on 6/24/09 and discharged home on 6/29/09. SN saw the patient on 6/30/09. There was no comprehensive resumption of care assessment dated 6/3/09 in the patient's clinical record.</p> <p>According to the agency's undated policy, C-155 Patient Reassessment/Update of Comprehensive Assessment, " ... Reassessments must be done at least: 1. Every second calendar month beginning with start of care 2. Within forty-eight (48) hours of (or knowledge of) patient return home from hospital admission of more than twenty-four (24) hours for any reason other than diagnostic testing..."</p> <p>On 9/17/09 in the afternoon, the director of professional services (DPS) indicated they were told by the Medicare HMO (health maintenance organization) referral source they only needed to complete OASIS(the Outcome and Assessment Information Set) comprehensive assessment forms upon the initial admission and the final discharge visits.</p>	G 340			